MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01540

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 8 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 1101 Pennsylwania Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: WALTER ADAMS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Viola Adams
6.(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) March 17, 1920

8. AGE: Years	Months	Days	If less than one day
24	1	3	....hrs. ....min.

9. Birthplace Hallifax, Va. (Town, county, and state)
10. Usual occupation Plummer
11. Industry or business Unknown
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Carrie Adams
15. Birthplace Unknown
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/25/45 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
Location C. G. County
18. Funeral director Adolphus Halstead
Address 918 Druid-Hill Ave.
19. 2/20 (Date rec'd by registrar) 19 45 Albert R. Swanhaven Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb., 20, 19 45, at 11.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12, 19 45 to Feb., 20, 19 45 and that I last saw h...im alive on February 20, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1944

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 2/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184a)

CERTIFICATE OF DEATH

01541

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Georeg A. Arnold

3.(b) Social Security Number 213-12-6487

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife A. Katherine Arnold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 26 1867

8. AGE: Years	Months	Days	If less than one day
77	3	9	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Manager

11. Industry or business Grain Warehouse

FATHER 12. Name Augustine Arnold

13. Birthplace Maryland

MOTHER 14. Maiden name Helen J. Spalding

15. Birthplace Penna.

16. Informant Charles R. Arnold

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/7/45 (month) (day) (year)

Cemetery or crematory St. Joseph's Cemetery

Location Taneytown, Md.

18. Funeral director C.O. Fuss & Son

Address Taneytown, Md.

19. Feb. 6, 1945 (Date rec'd by registrar) Ethele M. Melvin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 Sun 1945, at 10:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 Th 1944, to Feb 4 Sun 1945

and that I last saw h.. alive on Feb 4 Sun 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	3 days
Due to Arterio Sclerosis	
Due to Stroke and accident	3 mos.
Due to fall on Oct 27 Th 1944	3 mos.
Other conditions Fracture neck femur Left	
Left Humerus	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Oct 27 Th 1944

Where did injury occur? Taneytown (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury slipped fell on floor in Kitchen

23. SIGNATURE C. M. Benner MD M. D. or other

Address Taneytown Md Date signed 2-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

61542

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, Institution, or street address where death occurred:

Carroll County Home of The Aged

How long in hospital or institution? 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret V. Baile

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 8 - 1853

8. AGE: Years	Months	Days	If less than one day
91	4	20	..... hrs. ..... min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Lewis T. Baile

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Sarah Ann Pinkerton

15. Birthplace Carroll Co. Md.

16. Informant Carroll County records

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 3rd 1945 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Wakefield, Carroll Co. Md.

18. Funeral director J. Bankard Dean

Address Westminster, Md.

19. 3/ 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1944, to Feb. 28, 1945 and that I last saw h.. alive on Feb. 24 1945

Immediate cause of death	DURATION
Myocardial degeneration	1 yrs.
Due to	
Due to	
Chronic interstitial Nephritis	6 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Reese Wilkens M.D. or other

Address Westminster Date signed 3/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

(1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

(1543)

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Lyksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Lyksville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth C. Barnes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife Levi Barnes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 11, 1862

8. AGE: Years	Months	Days	If less than one day
82	8	22	....hrs. ....min.

9. Birthplace Carroll Co., Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Bennett

13. Birthplace England

MOTHER 14. Maiden name Elizabeth Roberts

15. Birthplace England

16. Informant Mrs. Ethel Melville

Address Lyksville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 4 1945 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Lyksville, Md.

18. Funeral director C. Harry Weer

Address Lyksville, Md.

19. Feb 3 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1945, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1944, to Feb 2 1945 and that I last saw h alive on Feb 1 1945

Immediate cause of death	DURATION
Pneumonia Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H A Barnes M.D.

M. D. or other

Address Lyksville Md. Date signed 2/3/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

01544

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 13 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 13 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 129 Independence St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME JOHN BERLIN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1894

8. AGE: Years	Months	Days	If less than one day
50	9	19	hrs. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual occupation Machinist
11. Industry or business Tire Factory
FATHER 12. Name Samuel Berlin
13. Birthplace W. Va.
MOTHER 14. Maiden name Cora Vititoe
15. Birthplace W. Va.
16. Informant Hospital records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 1, 1945 (month) (day) (year)
Cemetery or crematory Green Hill Cem.
Location Martinsburg, W. Va.
18. Funeral director Kagel Chaney & Coffman
Address Martinsburg, W. Va.

18. Feb 26 1945 C. Harry Wee Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945 at 6.17 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1945 to February 25 1945 and that I last saw him alive on February 25 1945

Immediate cause of death	DURATION
Chronic Myocarditis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichert, M.D. M. D. or other
Address U.S. Hosp. Sykesville, Md. Date signed 2-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

01545

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:
County Carroll
City or town Rural Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Clara L. Bohn

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

B.(b) Name of husband or wife Jesse M. Bohn
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 4, 1888

8. AGE:

Years	Months	Days	If less than one day
57	1	4	hrs. min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John W. Black
13. Birthplace Md

MOTHER
14. Maiden name L. Anna Bentz
15. Birthplace Md

16. Informant Jesse M. Bohn
Address Union Bridge, Md.
17. Burial (Burial, cremation, or removal? Which?) Date thereof Feb 11, 1945 (month) (day) (year)
Cemetery or crematory Berrett Dam
Location Nr. Union Bridge, Md.
18. Funeral director C. D. Russ & Son
Address Taneytown, Md.
19. Feb 10 1945 (Date rec'd by registrar) M. Eckman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1945, at 9 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1945 to Feb 9 1945
and that I last saw h.. alive on Feb. 9 1945

Immediate cause of death	DURATION
Carcinoma of Breast	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other
Address Union Bridge Date signed 2-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

01546

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother.)
State: Md. County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Sullivan Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Annie E Brown

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: John H Brown
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct 14, 1871

8. AGE: Years: 73 | Months: 4 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER 12. Name: Aaron Hilterbridle
13. Birthplace: Md

MOTHER 14. Maiden name: Ellen Formwalt
15. Birthplace: Md

16. Informant: Mrs Walter Shatto
Address: Westminster R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 3, 1945 (month) (day) (year)
Cemetery or crematory: Brudera
Location: near Westminster Md

18. Funeral director: C.O. Bair & Son
Address: Taneytown Md

19. 3/3 1945 (Date rec'd by registrar) H. Alexander Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28 1945, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2nd 1943 to Feby 28 1945 and that I last saw her alive on February 22 1945

Immediate cause of death	DURATION
acute cardiac relaxation	5 minutes
Due to: chronic Myocarditis	4 yrs.
Due to: Arterio Sclerosis	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Thos R Fout M D (M. D. or other)
Address: Westminster Md Date signed: 3/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01547

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 3 mo., 15 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1609 Druid Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: LEONARD BUTLER

3. (b) Social Security Number: 216-10-1547

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lillian Butler
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 13, 1919

8. AGE:

Years	Months	Days	If less than one day
25	5	28	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business:

FATHER
12. Name: Elisha Butler
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Otelia Brown
15. Birthplace: St. Mary's County, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 14-1945 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location:

18. Funeral director: Wm. George W. Stull
Address: 1631 Druid Hill Ave.

19. Feb. 10, 1945 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10, 1945, at 4:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26, 1942 to February 10, 1945 and that I last saw him alive on February 10, 1945

Immediate cause of death	DURATION
Tuberculosis of Spine	March 1940
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01548

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg,
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. R. #2
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: VERNON BUTLER

3. (b) Social Security Number: 218-16-0325

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 6, 1900

8. AGE:

Years	Months	Days	If less than one day
44	10	27	hrs. min.

9. Birthplace: Gaithersburg, Md.
(Town, county, and state)

10. Usual occupation: Farm worker

11. Industry or business

FATHER
12. Name: Mansfield Butler
13. Birthplace: Montgomery County, Md.

MOTHER
14. Maiden name: Elizabeth Weeks
15. Birthplace: Montgomery County, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-6-1945 (month) (day) (year)
Cemetery or crematory: Brookside Memorial
Location: Baltimore County, Maryland
18. Funeral director: Roy W. Barthmy
Address: Catonsville, Md.

19. Feb. 2, 1945 (Date rec'd by registrar) Albert R. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2, 1945, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 11, 1945, to Feb. 2, 1945 and that I last saw him alive on February 2, 1945

Immediate cause of death	DURATION
Lymphoma (Mediastinal glands)	7-30-43
Due to	
Due to	
Other conditions: Pulmonary tuberculosis	4-2-43

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH

01549

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yr., 6 mo., 3 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 11 yr., 6 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel Floyd Charlton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Minnie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 5, 1880

8. AGE: Years	Months	Days	If less than one day
64	2	1	..... hrs. ..... min.

8. Birthplace: Harrisonburg, Virginia
(Town, county, and state)
10. Usual occupation: Plasterer
11. Industry or business

FATHER
12. Name: Jasper Charlton
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mattie
15. Birthplace: Virginia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?), Date thereof 2 (month) 11 (day) 1945 (year)
Cemetery or crematory: Rosemont
Location: Williamsport, Maryland
18. Funeral director: Eslich & Leatherman
Address: Williamsport, Md.
19. Feb. 9 1945 (Date rec'd by registrar) C. Harry Eberly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 6 1945 at 5:15a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Feb. 6 1945 and that I last saw him alive on February 4 1945

Immediate cause of death	DURATION
General paralysis of the insane	14 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 2-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01550

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs., 1 month, 1 day
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 8 yrs., 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 821 Shakespeare Street (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Thomas Clemens

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Not known

6.(b) Name of husband or wife: Not known
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1877?

8. AGE: Years	Months	Days	If less than one day
68?	?	?	..... hrs. ..... min.

9. Birthplace: Not known (Town, county, and state)
10. Usual occupation: Not known
11. Industry or business:
FATHER — 12. Name: Not known
FATHER — 13. Birthplace: Not known
MOTHER — 14. Maiden name: Not known
MOTHER — 15. Birthplace: Not known
16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md
19. Feb. 8 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 6 1945, at 4:10a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1937, to Feb. 6 1945 and that I last saw h. 1m. alive on Feb. 5 1945

	DURATION
Immediate cause of death: Peritonitis	1 Day
Due to: Rupture of Gall-bladder	3 days
Due to:	
Other conditions: Pulmonary Tuberculosis	1937

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M Virginia Beyer M.D. (M. D. or other)
Address: Sykesville, Md Date signed: Feb. 6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of birthdate shown on Film G92 3/3/45 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

01551

Reg. Dist. No. 75

1. PLACE OF DEATH: County Carroll
City or town Rural – Manchester, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For stillborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6204 Birchwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Charles Marshall Covelly
3.(b) Social Security Number 217-07-5466

4. Sex male
5. Color or race white
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Beulah Covelly
7. Birth date of deceased (mo., day, yr.) June 26, 1904 (September 14, 1890)
6.(c) If alive, give age 40 years

8. AGE: Years 54 Months 5 Days 3 If less than one day ... hrs. ... min.

9. Birthplace Portland Maine (Town, county, and state)
10. Usual occupation Bricklayer
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace "
MOTHER 14. Maiden name Unknown
15. Birthplace "

16. Informant Mrs. Beulah Covelly
Address 6204 Birchwood Ave

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb. 22 1945 (month) (day) (year)
Cemetery or crematory Park Wood
Location Balto. Co. Parkville

18. Funeral director J. Leonard Ruck
Address 530 Harwood Rd. Balto, Md

19. Feb. 18 1945 Mrs. W. P. S. Penner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1945 at 3:47 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 1945 to Feb 18 1945 and that I last saw h... alive on February 18 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	16 hours
Due to: Hypertension	?
Due to: Chronic nephritis ?	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE L. V. Sobler, M. D. M. D. or other
Address Manchester, Md Date signed Feb 18 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

01552

CERTIFICATE OF DEATH

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 7 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 10 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro iofants give residence of mother)
State: Maryland County: Allegany
City or towo: Cumberland
(If outside city or town limits, write RURAL aod give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elmer Crowe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Adeline
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 1, 1898

8. AGE: Years	Months	Days	If less than one day
46	6	25	..... hrs. ..... min.

9. Birthplace: Garrett County, Maryland (Town, county, and state)
10. Usual occupation: Unk
11. Industry or business
FATHER 12. Name: Silas Crowe
13. Birthplace: Unk
MOTHER 14. Maiden name: Mary ?
15. Birthplace: Unk
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 1, 1945 (month) (day) (year)
Cemetery or crematory: Cumberland
Location: Allegany Co., Md.
18. Funeral director: C. Harry Wood
Address: Sykesville, Md.
19. Feb. 26, 1945 (Date rec'd by registrar) C. Harry Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1945, at 4:25 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26, 1944, to Feb. 26, 1945, and that I last saw him alive on February 25, 1945.

	DURATION
Immediate cause of death: Chronic valvular heart disease, prior to	1944
Due to: Streptococcus viridans encocarditis	
Due to: Bulbar paralysis, etiology unknown	5 yrs.
Due to: Adhesive pericarditis	
Other conditions: Undiagnosis psychosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 2-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01553

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Prince Georges

City or town Lyksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs 8 mos 26 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 20 yrs 8 mos 26 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3436 Olive Road

(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME Winifred Dorman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife Keith L. Dorman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) (Use 4 digits for year.) 1891

8. AGE: Years 54 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Mahoney - Thompson

13. Birthplace Mahoney Ireland

MOTHER 14. Maiden name Mahoney

15. Birthplace Mahoney Ireland

16. Informant Hospital records

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 24 1945 (month) (day) (year)

Cemetery or crematory St Joseph's Cem.

Location Boston, Mass

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Feb 20 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18th 1945, at 5 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 23rd 1944, to Feb 18th 1945

and that I last saw h.. alive on Feb. 17th 1945

	DURATION
Immediate cause of death	
Cerebral Hemorrhage (Acute)	7 yrs.
Due to Vascular Lesion	
Due to	
Other conditions Arteriosclerosis	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Maud M. Rees M.D.

M. D. or other

Address Sykesville Md. Date signed 2-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (62a)

CERTIFICATE OF DEATH

(1554

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 26 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 32 S. Mulberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
George Scott Drill

3.(b) Social Security Number
212-14-7172

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 3, 1866

8. AGE: Years	Months	Days	If less than one day
78	4	22	..... hrs. ..... min.

9. Birthplace Boonsboro-Wash.-Md
(Town, county, and state)
10. Usual occupation Night Watchman
11. Industry or business
FATHER 12. Name Henry Drill
13. Birthplace Boonsboro, Md.
MOTHER 14. Maiden name — Zeigler
15. Birthplace Boonsboro, Md.
16. Informant Springfield State Hosp. records
Address Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28-45 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Hagerstown, Md.
18. Funeral director Fred W. Krauss
Address Hagerstown, Md.
19. Feb 26 1945 (Date rec'd by registrar) C. Wesley Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945, at 11:00 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 30 1944, to Feb. 25 1945
and that I last saw him alive on February 25 1945

Immediate cause of death	DURATION
Senility	3 years
Due to	
Due to	
Other conditions Senile psychosis, simple deterioration	3 years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address Sykesville, Maryland Date signed 2-26-45

(M) (1) MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

01555

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:
County Carroll
City or town NEAR Eldersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural - Eldersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frederick Dutton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married.

6.(b) Name of husband or wife Nancy Dutton
6.(c) If alive, give age 95 years
7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
App. 102			hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Frederick Dutton
13. Birthplace Maryland.

MOTHER
14. Maiden name Nancy Rhenbottom
15. Birthplace Maryland

16. Informant Nancy Dutton
Address Sykesville Md

17. Burial Date thereof 2-21-45
(Burial, cremation, or removal? Which?) (month) (day) (year)
Cemetery or crematory White Rock
Location near Bennett Carroll Co Md

18. Funeral director C. M. Walsh
Address Winfield, Md

19. Feb. 20 1945 C. Harry Klees Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 17 1945 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Generalized arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE James T. Woods. Deputy Medical Examiner
M. D. or other
Address Westminster Md Date signed 2/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01556

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Cecilton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HELEN EMORY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 6, 1923

8. AGE: Years	Months	Days	If less than one day
21	9	17	hrs. min.

9. Birthplace: Cecilton, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: William Emory
13. Birthplace: Maryland

MOTHER
14. Maiden name: Arrie Sewell
15. Birthplace: Maryland

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. X Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28 1945 (month) (day) (year)
Cemetery or crematory: Cecilton Cemetery
Location: Cecilton, Md.

18. Funeral director: S. W Chase Sons
Address: 536 N Gilmore St

19. 2/23 19 45 (Date rec'd by registrar) Albert R Swarbaker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 1945, at 10.20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1945 to Feb. 23, 1945 and that I last saw h[illegible] alive on February 23, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: August 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Md. Date signed 2/23/45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-1)

01557

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 YRS

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER (If outside city or town limits, write RURAL and give nearest town)

Street No. 43 W. MAIN ST. (If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR I

3. (a) FULL NAME

EVERETT HOPKINS GAREY

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: HELEN M. BROWN

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): DECEMBER 31, 1891

8. AGE:

Years	Months	Days	If less than one day
53	2	23	...hrs. ...min.

9. Birthplace: DENTON, MD. (Town, county, and state)

10. Usual occupation: DENTIST

11. Industry or business

FATHER 12. Name: THOMAS F. GAREY

13. Birthplace: MD.

MOTHER 14. Maiden name: ANNA DIXON

15. Birthplace: MD.

16. Informant: MRS. E. H. GAREY

Address: WESTMINSTER, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)

Cemetery or crematory: BALTIMORE NATIONAL CEM.

Location: BALTIMORE, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 2/23 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 23 1945, at 6 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 1945, to February 23 1945

and that I last saw h... alive on February 23 1945

Immediate cause of death	DURATION
Acute Hemiplegia	2 hrs.
Due to Malignant Hypertension	1 Yr.
Due to Uremia - Acidosis (General)	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] (M.D. / M. D. or other)

Address: Westminster - Md. Date signed 2/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

01558

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown R.D. (Taneytown Dist)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PA. County Adams
City or town Littlestown, R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Enoch David Healy

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sarah Healy
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Aug. 22 - 1855

8. AGE: Years 89 | Months 5 | Days 27 | If less than one day ... hrs. ... min.

9. Birthplace Adams Co. PA
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Farm

FATHER
12. Name Jacob Healy
13. Birthplace France

MOTHER
14. Maiden name Rebecca Nicholls
15. Birthplace Adams Co. PA

16. Informant Ralph Healy
Address Westminster, Md

17. Burial Date thereof Feb. 22-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Johns Cemetery
Location Littlestown, PA

18. Funeral director J. M. Little & Son
Address Littlestown, PA Pa R 4.

19. Feb. 22. 1945 Ethel M Mehring Registrar
(Date rec'd by registrar)

Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1945, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 23 1944, to Feb. 19 1945 and that I last saw him alive on Feb. 19 1945

Immediate cause of death	DURATION
Chronic Myocarditis and Myocardial degeneration - Not Rheumatic	25 yrs.
Due to Chronic Nephritis + Uremia	20 yrs.
Due to Hypertrophy of the prostate	15 yrs.
Other conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results Not Done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D.
M. D. or other
Address Taneytown, Md. Date signed 2/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM NO. G94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01559

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 6 mon. ½ day
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yrs. 6 mon. ½ day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Edward Geckle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. (?) 18-76 1875

8. AGE: Years	Months	Days	If less than one day
69 -69-	6		hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Bristle comber
11. Industry or business

FATHER
12. Name: Charles Geckle
13. Birthplace: Germany

MOTHER
14. Maiden name:
15. Birthplace: Germany

16. Informant: Mrs. Mary E. Kelso, sister
Address: 1140 Montpelier St., Balto., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 23, 1945 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cem.
Location: Balto. Md.
18. Funeral director: William Cook Inc.
Address: 1217 N. Paca St.
19. Feb 20 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 1945 at 11 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 1945 to Feb. 20 1945 and that I last saw him alive on Feb. 20 1945

Immediate cause of death	DURATION
Carcinoma of head of pancreas	months.
Due to	
Due to	
Other conditions: Psychosis c Cerebral arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward F. Kerman M. D. or other
Address: Sykesville, Md. Date signed: 2-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01560

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES CARDINAL GRAY

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Clara Gray
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 27, 1908

8. AGE: Years	Months	Days	If less than one day
36	5	30	..... hrs. ..... min.

9. Birthplace: Hughesville, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Timothy Gray
13. Birthplace: Unknown

MOTHER
14. Maiden name: Dalphine Wright
15. Birthplace: Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/1/45 (month) (day) (year)
Cemetery or crematory: St. Philip's Church Cem.
Location: Aquasco Md.
18. Funeral director: Eugene C. Gwynn
Address: Aquasco, Md.

19. Feb. 26, 1945 (Date rec'd by registrar) Albert L. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1945, at 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 22, 1945 to Feb. 26, 1945 and that I last saw him alive on February 26, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

01561

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1709 Cario Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: AMELIA JULIA GREEN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug., 16, 1912

8. AGE: Years	Months	Days	If less than one day
32	5	25	hrs. min.

9. Birthplace: Savannah, Ga. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Wesley Williams
13. Birthplace: Savannah, Ga.

MOTHER
14. Maiden name: Annie Hughes
15. Birthplace: Savannah, Ga.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial, cremation, or removal. Which? Burial Date thereof: Feb 12 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cem
Location: Baltimore
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St.

19. 2/8 1945 (Date rec'd by registrar) Albert R. Swanborne Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8, 1945 at 4.30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 15, 1944 to Feb., 8, 1945 and that I last saw her alive on February 8, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 2/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01562

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 6 mo., 22 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 531 N. Bond Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BURRELL GREEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Sarah Green

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): April 25, 1895

8. AGE: Years	Months	Days	If less than one day
49	9	17	....hrs. ....min.

9. Birthplace: Homewood, Virginia

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: General Green

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Mattie Brodnax

15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 5th 45 (month) (day) (year)

Cemetery or crematory: Mt. Calvery Cem. Lutheran

Location: Brooklandville Md

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantley Ave.

19. Feb. 11, 45 (Date rec'd by registrar) Albert R. Swarbrick Deputy Local Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: February 11, 19 45 at 11:00 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 20, 19 43 to Feb. 11, 19 45 and that I last saw h im alive on February 11, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed 2-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01563

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll Co.

City or town near Sandus Road

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) about 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll Co.

City or town New Gamber Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. New Gamber, 10 Miles south of Westminster

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MARY V. HANSON

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
f.	W.	Married

6 (b) Name of husband or wife Charles W. Hanson

6(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) not known

8. AGE: Years: about 59 | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace Countalk W. Va. Frenbrier Co.

(Town, county, and state)

10. Usual occupation Home-wife

11. Industry or business

FATHER 12. Name Wallace Crookshanks

13. Birthplace W. Va.

MOTHER 14. Maiden name Isabelle Happlette

15. Birthplace West Va.

16. Informant Charles W. Hanson

Address Sykesville RD 1 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/3/45 (month) (day) (year)

Cemetery or crematory James Chapel

Location Clintonville, Frenbrier Co. W. Va.

18. Funeral director J. E. Myers, Jr.

Address Westminster, Md.

19. 3/27/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26, 1945 19____, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-14-45 19____, to 2-26-45 19____, and that I last saw her alive on 2-23-45 19____.

Immediate cause of death Coronary Thrombosis — DURATION 10 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE James V. Saffell M. D. or other

Address Reisterstown Md. Date signed 3/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

01564

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yr., 8 mo., 24 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 15 yr., 8 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Joseph B. Harrison

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1891

8. AGE: Years	Months	Days	If less than one day
53	9	3	hrs. min.

9. Birthplace: Baltimore City, Maryland (Town, county, and state)
10. Usual occupation: Optician & optometrist
11. Industry or business: Optical

FATHER
12. Name: George Harrison
13. Birthplace: St. Mary's County, Maryland

MOTHER
14. Maiden name: Mary A. Brooks
15. Birthplace: Allegany County, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-7-45 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: 4300 Old Frederick Rd.
18. Funeral director: Chas. F. Evans & Son.
Address: 118 W. Mt. Royal Ave.
19. Feb. 4 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 19 45 at 10:50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to Feb. 4 19 45
and that I last saw him alive on February 4 19 45

Immediate cause of death	DURATION
Chronic endocarditis (valvular heart disease	35 yr.
Due to:	
Due to:	
Other conditions: Dementia precox, hebephrenic type	21 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 2-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

01565

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in abeve place of death? 1 yr. 10 mon. 25 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr. 10 mon. 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: Benjamin F. Hobbs

3. (b) Social Security Number: 215-22-9437

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Cecellia Schrufer Hobbs
1903 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 11, 1898

8. AGE: Years	Months	Days	If less than one day
47	1	8	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Lithographer
11. Industry or business

FATHER
12. Name: James B. Hobbs
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Veritll
15. Birthplace: Maryland

16. Informant: Mrs. Nellie Piercy, sister
Address: 1441 N. Bond St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 22, 1945 (month) (day) (year)
Cemetery or crematory: Baltimore Cemetery
Location: Balto., Md.

18. Funeral director: William Cook Inc.
Address: 1217 E. Fayette St. Balto. Md.

19. Feb 20 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19 1945 at 12 55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1943 to Feb. 19 1945
and that I last saw h.i.m. alive on Feb. 19 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	1 year
Due to:	
Due to:	
Other conditions: Psychosis & Huntington's Chorea (Include pregnancy within 3 months of death)	2 yrs.

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edward J. Kernan M. D. or other
Address: Sykesville, Md. Date signed 2-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01566

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 11 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 733 Stirling St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: SHIRLEY HOWARD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 11, 1939

8. AGE: Years	Months	Days	If less than one day
5	7	17	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Charles Elliott
13. Birthplace: Unknown
MOTHER 14. Maiden name: Pearl Howard
15. Birthplace: Baltimore, Md.
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/3/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A.A. Co Md
18. Funeral director: Isaiah L Brocenton
Address: 1080 Montgomery Street
19. Feb. 28, 45 (Date rec'd by registrar) Albert Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28, 1945 at 1:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1944, to Feb. 28, 1945 and that I last saw her alive on February 28, 1945

Immediate cause of death	DURATION
Tuberculous Meningitis	2-26-45
Due to: Pulmonary Tuberculosis	7-16-44
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 2-28-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01567

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 YEARS

Hospital, institution, or street address where death occurred:

M. P CHURCH HOME FOR AGED

How long in hospital or institution? 7 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No. E. MAIN ST.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: ANDREW M. HUNTER

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: EMMA C. BREGEL

6.(c) If alive, give age: 87 years

7. Birth date of deceased (mo., day, yr.): MARCH 17, 1853

8. AGE: Years	Months	Days	If less than one day
91	10	16	...hrs. ...min.

9. Birthplace: BALTIMORE, MD (Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business:

FATHER — 12. Name: ANDREW HUNTER

13. Birthplace: MARYLAND

MOTHER — 14. Maiden name: ELIZABETH WEST

15. Birthplace: MARYLAND

16. Informant: MRS D.S SEHR

Address: WESTMINSTER, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/5/45 (month) (day) (year)

Cemetery or crematory: BALTIMORE CEMETERY

Location: BALTIMORE MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 2/3 (Date rec'd by registrar) 19 45 — L K Woodward, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 7 1945 at 6.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/2 19 45 to 2/7 19 45 and that I last saw h... alive on 2/2 19 45.

	DURATION
Immediate cause of death: Coronary Occlusion	7 hrs
Due to: Chr. Myocarditis	many yrs
Due to: Arteriosclerosis	yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L K Woodward, M. D. or other

Address: Westminster Date signed 2/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01568

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 902 Park Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GRACE IRBY

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Irby
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19, 1917

8. AGE: Years	Months	Days	If less than one day
27	10	8	hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: Henry Lambert
13. Birthplace: Blackstone, Va.

MOTHER
14. Maiden name: Christine Pegan
15. Birthplace: Blackston, Va.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. (Burial, cremation, or removal. Which?) Removal Burial
Date thereof (month) (day) (year) 3/3/45
Cemetery or crematory: Mt. Auburn Williams Cemetery
Location: Balto. Md. Crewe, Virginia

18. Funeral director: Chas. L. Cooper
Address: 512 N. Carrollton Ave.

19. 2/27 (Date rec'd by registrar) 19 45 Albert L. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27, 19 45 at 4.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 19 44 to Feb. 27, 19 45 and that I last saw her alive on February 27, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1943

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 2/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

01569

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 4 mo's., 3 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1113 W. Lexington Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES EDDIE JACKSON

3.(b) Social Security Number: 216-05-1539

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Fannie Jackson
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): April 10, 1904

8. AGE: Years	Months	Days	If less than one day
40	9	28	..... hrs. ..... min.

9. Birthplace: Calvert County, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: Addie Chase
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alexander Jackson
15. Birthplace: Maryland

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto. Md.
18. Funeral director: Charles H. Cooper
Address: 512 N. Carrollton Ave.

19. 2/7 (Date rec'd by registrar) 19 45 Albert R. Swankham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7, 19 45 at 12.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4, 19 43 to Feb. 7, 19 45
and that I last saw him alive on February 7, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1943

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 2/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01570

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No.: WESTERN MARYLAND COLLEGE

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM EDGAR JACKSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: SARAH MAXWELL

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 3, 1868

8. AGE: Years: 76 Months: 3 Days: 7 If less than one day: ..... hrs. ..... min.

9. Birthplace: CARROLL N.Y. (Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business

FATHER 12. Name: JAMES JACKSON

13. Birthplace: NEW YORK

MOTHER 14. Maiden name: MARY ADAMS

15. Birthplace: NEW YORK

16. Informant: MRS. F. G. HOLLOWAY

Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 2/13/45 (month) (day) (year)

Cemetery or crematory: WESTMINSTER CEM.

Location: WESTMINSTER, MD.

18. Funeral director: V. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 2/12/45 (Date rec'd by registrar) 19.... F. G. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 10 19 45, at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 24 19 45 to Feb 10 19 45

and that I last saw h... alive on Feb. 10 19 45

	DURATION
Immediate cause of death: Bronchopneumonia	3 Days
Due to: Arteriosclerotic Cardio-Vascular Renal	7 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings at operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James F. Shank M. D. or other

Address: Hanover, Pa. Date signed 2/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

CERTIFICATE OF DEATH

01571

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elsie Kelly

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Percy Kelly
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Dec 4 1881

8. AGE: Years	Months	Days	If less than one day
63	2	15	....hrs. ....min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: S. B. Norwood
13. Birthplace: Md

MOTHER
14. Maiden name: Laura Hood
15. Birthplace: Md

18. Informant: Percy Kelly
Address: Mt Airy Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 21 - 45 (month) (day) (year)
Cemetery or crematory: New Market Cemetery
Location: New Market Md

18. Funeral director: W. E. Fahrney
Address: New Market Md

19. Feb 19 1945 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19 1945, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1943 to Feb 19 1945 and that I last saw her alive on Feb 19 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 dys.
Due to: Arterio Sclerosis (Cerebral)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm Van Poole M. D. or other
Address: Mt Airy Md Date signed: 2/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83d)

01572

CERTIFICATE OF DEATH

Reg. Dist. No. 7d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Caroline
City or town Tanneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Mary Jane Kiser

3.(b) Social Security Number None

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife John H Kiser
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1869

8. AGE: Years 75 | Months 10 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Wiate Royer
13. Birthplace Md

MOTHER 14. Maiden name Isabella Spangler
15. Birthplace Ca

16. Informant Mrs Grace Meding
Address Dundalk Md

17. Burial Date thereof Feb 28, 1945
(Burial, cremation, or removal? Which?) (month) (day) (year)
Cemetery or crematory Lutheran
Location Taneytown Md

18. Funeral director Colt Fuss & Son
Address Taneytown, Md.

19. Feb 27 1945 Ethel M Mehring Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25th 1945 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24th 1945 to Feb. 25th 1945 and that I last saw h.. alive on Feb. 25th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Arterio Sclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. M. Benner M D
M. D. or other
Address Taneytown Md Date signed 3/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01573

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yr., 5 mo., 26 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 7 yr., 5 mo., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1743 Belt St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Knickman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
9.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1886

8. AGE: Years	Months	Days	If less than one day
~~60~~ (?) 59			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER 12. Name: John Knickman
13. Birthplace: Maryland

MOTHER 14. Maiden name: Stully
15. Birthplace: Maryland

18. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/45 (month) (day) (year)
Cemetery or crematory: Baltimore Cemetery
Location: North Ave. above Milton Ave.

19. Funeral director: Howard N. Blight, Jr.
Address: 4914 Belair Road

19. 2/10 (Date rec'd by registrar) 19 45 R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 19 45 at 5:20a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to Feb. 9 19 45
and that I last saw him alive on February 8 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	6 days
Due to: Senility	1 year
Due to:	
Other conditions: Without psychosis, mental deficiency	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 2-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01574

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown Md RD #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Town Dale

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Nellie Marie Knight

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 3, 1945

8. AGE:

Years	Months	Days	If less than one day
0	0	1	hrs. min.

9. Birthplace: Taneytown-Taneytown Md

(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Samuel Bennett Knight

13. Birthplace: Maine Florida

MOTHER

14. Maiden name: Addie Mae Osborne

15. Birthplace: Lee County Va

16. Informant: Addie Mae Osborne

Address: Taneytown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-5-45 (month) (day) (year)

Cemetery or crematory: Emory Church

Location: Carroll Co. Md

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. 2-6-45 (Date rec'd by registrar) 19 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 19 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 19 — to Feb 4 19 45

and that I last saw h alive on Feb 3 19 45

Immediate cause of death	DURATION
Hemorrhagic Disease of New Born	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Maurice C. Porterfield Acting Deputy Medical Exam (Carroll Co) M. D. or other

Address: Hampstead Md Date signed 2-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01575

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 578 Oxford Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ELIZABETH LEGGETT

3.(b) Social Security Number: 213-18-6475

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Vernon Leggett
6.(c) If alive, give age: 28 years
7. Birth date of deceased (mo., day, yr.): Jan. 20, 1918

8. AGE: Years	Months	Days	If less than one day
27	1	1	....hrs. ....min.

9. Birthplace: Aiken, S.C. (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business

FATHER
12. Name: Thomas Williams
13. Birthplace: Aiken, S.C.

MOTHER
14. Maiden name: Maggie Brown
15. Birthplace: Aiken, S.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27-1945 (month) (day) (year)
Cemetery or crematory: Arbutus Mem Park
Location: Baltimore, Md.

18. Funeral director: Mrs Lowery A Hall
Address: 1631 Druid Hill Ave

19. Feb. 21, 19 45 (Date rec'd by registrar) Albert R. Scandlon Deputy Local Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: Feb. 21, 19 45, at 8:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 9, 19 45, to Feb. 21, 19 45
and that I last saw her alive on February 21, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 2-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01576

Reg. Dist. No. 72

1. PLACE OF DEATH

County: Carroll

City or town: Silver Run (Westminster R. D.)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Silver Run

(If outside city or town limits, write RURAL and give nearest town)

Street No. Westminster R. D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Martha Jane Mans

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: F. Harvey Mans

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): May 14 1872

8. AGE: Years: 72 | Months: 8 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Adams County PA.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER

12. Name: Silas Mc Harner

13. Birthplace: Adams County PA

MOTHER

14. Maiden name: Mary E. Roberts

15. Birthplace: Adams County PA

18. Informant: Stanley D. Harner

Address: Westminster Md R. D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 7. 1945 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Silver Run, Md.

18. Funeral director: J. M. Little & Son

Address: Littlestown, PA Rt. R. 1

19. Feb. 6th 1945. (Date rec'd by registrar) Asbury D. Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1945, at 12:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1943, to Feb. 4 1945

and that I last saw her alive on Feb 4 1945

Immediate cause of death	DURATION
Chronic myocardial disease	10 yrs.
Due to	
Due to	
Other conditions: Hypertension	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dowell B Cooper M.D.

Address: Littlestown Pa Date signed: 2-5-45 M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

01577

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Melrose
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One year
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Melrose
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Adam Markle.

3.(b) Social Security Number: 226-18-2464

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Lillie Mary Markle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	0	..... hrs. ..... min.

9. Birthplace: Manchester Md. (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business: Agriculture
FATHER 12. Name: Eli Adam Markle
13. Birthplace: Maryland
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Mrs Charles Stork
Address: Manchester Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-9-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Weiker Sons
Address: Manchester Md
19. Feb 7 1945 (Date rec'd by registrar) M/o W. R. J. Demmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6, 1945 at 10:55 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1945, to Feb. 6, 1945 and that I last saw h. alive on Feb. 6, 1945

Immediate cause of death	DURATION
Cerebral Haemorrhage	1 hour
Due to Hypertension	Unknown
Due to Arterio-Sclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Edgar M. Bush M.D. M. D. or other
Address: Hampstead Md. Date signed 2/6/1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01578

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Allendale Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret E. Megee

3. (b) Social Security Number 212-01-9852

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1888

8. AGE:

Years	Months	Days	If less than one day
56	4	10	..... hrs. ..... min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name John H. Megee

13. Birthplace New Jersey

MOTHER 14. Maiden name Ella M. Crass

15. Birthplace Maryland

16. Informant Mrs. Pius L. Shenker

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 17, 1945 (month) (day) (year)

Cemetery or crematory New Cathedral Cemetery

Location Baltimore, Md (4300 old Frederick Rd)

18. Funeral director C. O. Guest & Son

Address Taneytown, Md.

19. Feb. 16 1945 Ethele M Mehring

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 1945, to Feb 15 1945 and that I last saw h.er alive on Feb 15 1945

	DURATION
Immediate cause of death Coronary Embolism	3 days
Due to Diabetes Mellitus with abscess foot	6 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner MD M. D. or other

Address Taneytown MD Date signed 2/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01579

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 3 mo's, 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
KING SOLOMON MILLER

3.(b) Social Security Number
705-09-7569

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Jessie B. Miller
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 12, 1902

8. AGE: Years	Months	Days	If less than one day
42	4	11	hrs. min.

9. Birthplace Aberdeen, Md.
(Town, county, and state)
10. Usual occupation Railroad Trackman
11. Industry or business Unknown
FATHER 12. Name Friday Miller
13. Birthplace South Carolina
MOTHER 14. Maiden name Christie Brown
15. Birthplace South Carolina
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 23 45 (month) (day) (year)
Cemetery or crematory
Location Aberdeen, Md
18. Funeral director Elmer E. Bullock
Address 556 Lewis St. Havre de Grace
19. 2/23 (Date rec'd by registrar) 19 45 Albert R. Lowenhaupt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1945 at 8.00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29, 1943 to Feb., 23, 1945 and that I last saw him alive on February 23, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 5, 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M. D. M. D. or other
Address Henryton, Md. Date signed 2/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

01580

Reg. Diat. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Ridgeville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Ridgeville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Charles Robert Mosley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Madeline Mosley

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 31 1894

8. AGE: Years	Months	Days	If less than one day
60	8	16	..... hrs. ..... min.

9. Birthplace: Frederick Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Jehiel Mosley

13. Birthplace: Montgomery

MOTHER — 14. Maiden name: Hattie Mosley

15. Birthplace: Montgomery Co. Md.

16. Informant: Madeline Mosley

Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 18, 1945 (month) (day) (year)

Cemetery or crematory: Montgomery Chapel

Location: Near Damascus, Montgomery Co. Md.

18. Funeral director: H. M. Snyder

Address: Mt. Airy Md.

19. Feb. 17 1945 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other

Address: Lee Windsor Md. Date signed: Feb 16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

- CERTIFICATE OF DEATH

01581

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH.

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs 11 mos 16 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 yrs 11 mos 16 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 613 E 33 d St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Emma S Myers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

8.(b) Name of husband or wife: —

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 1862

8. AGE: Years: 82 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

12. FATHER — Name: Fredrick Tawney

13. FATHER — Birthplace: Maryland

14. MOTHER — Maiden name:

15. MOTHER — Birthplace: —

16. Informant: Arthur Granville

Address: 613 E 33 d St Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 1, 1945 (month) (day) (year)

Cemetery or crematory: Md. Object Asm.

Location: Bald. Md.

18. Funeral director: Wm Cook Inc

Address: 1217 N. Paul St.

19. Feb 27 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27 1945, at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 11th 1940 to Feb 27 1945

and that I last saw h[illegible] alive on Feb 27 th 1945

Immediate cause of death	DURATION
Chronic Endocarditis	4 yrs
Due to:	
Due to: Arteriosclerosis	?
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Gaston M.D.

M. D. or other

Address: Sykesville Date signed: 2/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01582

Reg. Diat. No. 70

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Taneytown Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Albert J. Ohler

3. (b) Social Security Number none

4. Sex: M | 5. Color or race: W | 6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Carrie R. Ohler 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 25, 1867

8. AGE: Years: 77 | Months: 4 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Andrew J. Ohler

13. Birthplace: Md

MOTHER 14. Maiden name: Mary E. Bleagle

15. Birthplace: Md

16. Informant: Mrs. A. J. Ohler

Address: Taneytown Md

17. Burial (Burial, cremation, or removal) Date thereof Mar 3, 1945 (month) (day) (year)

Cemetery or crematory: Lutheran

Location: Taneytown, Md

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19. March 2, 1945 (Date rec'd by registrar) Ethele M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1945 at 11:57 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 1945 to Feb 28 1945 and that I last saw him alive on Feb 28 1945

	DURATION
Immediate cause of death: Angina Pectoris	9 days
Due to: Arterio Sclerosis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner M.D. M. D. or other

Address: Taneytown Md Date signed 3/2/1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for item 10 & 11- phone call from undertaker 2/15/45 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

61583

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 9 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson, 4

(If outside city or town limits, write RURAL and give nearest town)

Street No. 617 York Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Louis Krebs Owen

3.(b) Social Security Number: 212-03-1469

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Sara F. Owen

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 17, 1889

8. AGE: Years	Months	Days	If less than one day
55	10	27	..... hrs. ..... min.

9. Birthplace: Baltimore City, Maryland (Town, county, and state)

10. Usual occupation: Bookkeeper & Manager

11. Industry or business: Self - Chesapeake Manufacturing Co.

FATHER — 12. Name: George F. Owen

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Smith

MOTHER — 15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cem.

Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 2-16-45 (Date rec'd by registrar) 19..... G. W. Herrick per HH Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 19 45 at 10:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 19 44 to Feb. 14 19 45 and that I last saw him alive on February 14 19 45

Immediate cause of death	DURATION
Arteriosclerosis	7 years
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	2 years

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D. Robert Bertrand May, M.D.

Springfield State Hospital M.D. or other

Address: Sykesville, Maryland Date signed 2-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15-1

Rec'd. U. S.
7/15/45

01584

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: near Sykesville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 11 mos., 16 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 3 yrs., 11 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 502 Hollen Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Albert Pedro

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Bessie Tawkersly
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Exact date unknown.

8. AGE: Years	Months	Days	If less than one day
68 (?)	?	?	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Odd jobs.
11. Industry or business

FATHER
12. Name: Albert J. Pedro
13. Birthplace: Portugal

MOTHER
14. Maiden name: Frances Edkins
15. Birthplace: Surrey, England

16. Informant: Springfield Hospital Record
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 26 1945 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Balto. Md.

18. Funeral director: John C. Mitchell & Sons
Address: 1900 Eutaw Place

19. Feb 22 1945 (Date rec'd by registrar) C. Harry Ware Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22, 1945 at 1:15p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1944 to February 22, 1945 and that I last saw h...im...alive on February 22, 1945

Immediate cause of death	DURATION
Cerebral arteriosclerosis	
prior to	3-6-41
Due to	
Due to	
Other conditions: Psychosis with cerebral	
arteriosclerosis prior to	3-6-41

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D. M. D. or other
Address: Sykesville, Md. Date signed: 2-22-45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

01585

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One year
Hospital, institution, or street address where death occurred:
How long in hospital or institution? None -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LAURA A. RILL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George Washington Rill
6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Nov 1 - 1864

8. AGE:

Years	Months	Days	If less than one day
80	3	14	....hrs. ....min.

9. Birthplace: Baltimore Co. Maryland
(Town, county, and state)
10. Usual occupation: Housework -
11. Industry or business:
FATHER 12. Name: William Booben -
13. Birthplace: Maryland -
MOTHER 14. Maiden name: Hannah Frock.
15. Birthplace: Maryland -
16. Informant: George W. Rill
Address: Westminster, Maryland R.F.D. 3.
17. Burial ✓ (Burial, cremation, or removal. Which?) Date thereof 2-18-45 (month) (day) (year)
Cemetery or crematory: Wesley
Location: Carroll County
18. Funeral director: Edw. C. Fipeton
Address: Hampstead Md
19. Feb 17 (Date rec'd by registrar) 1945 M 20 W. P. S Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15th 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1944, to February 15th 1945
and that I last saw h.... alive on February 14th 1945

Immediate cause of death: Acute Coronary Thrombosis — DURATION: 2 hrs -
Due to: Chr. Nephritis — 6 yrs.
Due to: Chr. Cystitis - Adenoma — 10 years
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles Bon (MD) M. D. or other
Address: Westminster Maryland Date signed 3/15/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01583 Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida Loring Rucker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife Wm B. Rucker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4, 1856

8. AGE: Years	Months	Days	If less than one day
88	11	24	..... hrs. ..... min.

8. Birthplace Amherst, Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home.

FATHER 12. Name Baron Higinbotham

13. Birthplace Va.

MOTHER 14. Maiden name Sallie Sandidge

15. Birthplace Va.

18. Informant Mr. Samuel Richeson

Address Sykesville, Md.

17. Burial Date thereof Mar. 1, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Grove Cemetery

Location Glenwood, Howard Co., Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Mar. 1 1945 C. Harry Weer (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1945 at 10:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23 1945, to February 26 1945 and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	
following accidental fall	
Due to Fracture of r. radius & ulna	
Due to accidental fall	
Other conditions senility	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 2/23/45

Where did injury occur? Sykesville (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury fell down stairs Injured at work? no

23. SIGNATURE Wm H. Lawrence M. D. M. D. or other

Address Sykesville, Md. Date signed Feb 27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

01587

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 514 Washington Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Sheldon.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ida Weise

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 25 - 1861

8. AGE:

Years	Months	Days	If less than one day
83	1	22	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Huckster

11. Industry or business

FATHER
12. Name John Sheldon.
13. Birthplace Maryland

MOTHER
14. Maiden name Barnes
15. Birthplace Maryland

16. Informant Hospital records
Address Sykesville, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Feb. 20, 1945 (month) (day) (year)

Cemetery or crematory Loudon Park Cemetery

Location Balto. Md.

18. Funeral director Cushnan Inc.

Address 412 N. Franklintown Rd.

19. Feb. 16 1945 C. Harry Klee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 1943, to February 16 1945 and that I last saw him alive on February 15 1945

Immediate cause of death	DURATION
Chronic Myocarditis and	Known
Myocardial degeneration	Feb. 12. 45
Due to	
Due to	
Other conditions Cerebral Arteriosclerosis	More than 5 years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE M. Virginia Berger M.D.
M. D. or other

Address Sykesville, Md. Date signed Feb. 16. 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01588

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr., 4 mo., 24 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 4 yr., 4 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles Harold Sheppard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Sadie V. Mimick

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 19, 1888

8. AGE: Years	Months	Days	If less than one day
56	3	6	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Sales clerk

11. Industry or business: Hardware, retail

FATHER 12. Name: Benjamin F. Sheppard

FATHER 13. Birthplace: Baltimore, Maryland

MOTHER 14. Maiden name: Alice Burton

MOTHER 15. Birthplace: Baltimore, Maryland

16. Informant: Records, Springfield State Hosp.

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 1, 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. Feb. 26 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1945 at 10:10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Feb. 25 1945 and that I last saw him alive on February 25 1945

Immediate cause of death	DURATION
General paralysis of the insane	6 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D.

M. D. or other

Springfield State Hospital Sykesville, Maryland

Address: Date signed: 2-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01589

Reg. Dist. No. 42.

1. PLACE OF DEATH:
County Carroll
City or town Union Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 93
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis Edwin Shriver

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1851

8. AGE:	Years	Months	Days	If less than one day
	93	2	15	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
12. FATHER Name Graduan L. Shriver
13. Birthplace Md.
14. MOTHER Maiden name Katherine Wirt
15. Birthplace Hanover, Pa.
16. Informant Mrs. Elizabeth Kemp
Address Union Mills, Carroll Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5 - 1945 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Hanover, Pa.
18. Funeral director Frederick Bucher
Address Hanover, Pa.
19. Feb 3rd 1945 (Date rec'd by registrar) Calvin Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 2nd 1945, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 21 - 1945, to Feby 2 - 1945 and that I last saw him alive on Feby 2 - 1945

Immediate cause of death	DURATION
acute dilatation of heart	20 mm
Due to Chronic myocarditis	5 yrs
Due to arterio sclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. R Foutz MD M. D. or other
Address Westminster Date signed 2-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01590

Reg. Dist. No. 7D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mrs Emma J. Smith | **3.(b) Social Security Number** none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Wm J. Smith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 20, 1857

8. AGE: Years	Months	Days	If less than one day
87	5	21	hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Daniel Hesson
13. Birthplace: Md
MOTHER 14. Maiden name: Elizabeth Shriner
15. Birthplace: Md
16. Informant: Ernest J. Smith
Address: Taneytown R.D 3
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 13, 1945 (month) (day) (year)
Cemetery or crematory: Piney Creek Presbyterian
Location: Taneytown, Rural
18. Funeral director: Ed Diss & Son
Address: Taneytown, Md.
19. Feb 13 1945 Ethel M Mehring Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 11 1945 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1945, to Feb 11 1945
and that I last saw h.. alive on Feb 11 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to: Arterio Sclerosis	3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner M.D. M. D. or other
Address: Taneytown Md Date signed 2/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2) ✓

CERTIFICATE OF DEATH

01591

Reg. Dist. No. 6P

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Luther Stultz

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ada Stultz

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb 25 - 1888

8. AGE: Years	Months	Days	If less than one day
56	11	25	____ hrs. ____ min.

9. Birthplace: Carroll County, Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: George Stultz
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Bloom
15. Birthplace: Maryland

16. Informant: Mrs. Ada Stultz
Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 22 1945 (month) (day) (year)

Cemetery or crematory: Winters Cemetery

Location: Union Bridge Road

18. Funeral director: C. W. Hartsler & Sons
Address: Union Bridge & New Windsor Md

19. Feb 22 1945 (Date rec'd by registrar) Emma S Bunds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19 1945 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1944, to Feb 19 1945, and that I last saw h. alive on Feb 19 1945

Immediate cause of death	DURATION
(a) Carcinoma Intestines	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: J. N Legg M. D. or other

Address: Union Bridge Date signed: 2/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

01592

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH: Carroll.
County.....
City or town Near Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs., 2 mos., 18 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital.
How long in hospital or institution? 14 yrs., 2 mos., 18 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Montgomery
City or town Boyds.
(If outside city or town limits, write RURAL and give nearest town)
Street No. # Unknown.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME Milton Thompson.

3.(b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Divorced.

6.(b) Name of husband or wife.....
6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) November 6, 1900.

8. AGE: Years	Months	Days	If less than one day
44.	3.	16.	.....hrs. .....min.

9. Birthplace Montgomery County, Md.
(Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business Farm.
FATHER 12. Name William Thompson.
13. Birthplace Maryland.
MOTHER 14. Maiden name Gertrude Price.
15. Birthplace Maryland.
16. Informant Springfield Hospital Record.
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 25. 45 (month) (day) (year)
Cemetery or crematory Hyattstown Cemetery
Location Hyattstown, Maryland
18. Funeral director E. C. Gartner
Address Gaithersburg, Md.
19. Feb. 23 1945 (Date rec'd by registrar) C. Harry Elseroad Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945 at 9 p. m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936 to Feb. 22, 1945
and that I last saw h. alive on February 22, 1945

Immediate cause of death	DURATION
Post-Encephalitis — prior to	12-4-30.
Due to.....	
Due to.....	
Due to Psychosis with Organic Brain	
Other conditions and nervous disease —	
Post-Encephalitis — prior to	12-4-30.

(Include pregnancy within 3 months of death)

Major findings of operations.....
.....Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Harry J. Baer, M. D.,
M. D. or other
Address Sykesville, Md. Date signed 2-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

01593

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years 5 months 9 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 16 years 5 months 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Harmony Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Jennie E. Wachter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Millard Wachter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., dy., yr.): August 23, 1898

8. AGE: Years	Months	Days	If less than one day
46	5	14	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Isaac Rice
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Shenkle
15. Birthplace: Maryland

16. Informant: Hospital record
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10, 1945 (month) (day) (year)
Cemetery or crematory: Zion Cemetery
Location: Charlesville, Md.

18. Funeral director: M. R. Etchison & Sons
Address: Frederick, Md.

19. Feb 7 19 45 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 19 45, at 1.40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 19 42, to February 6 19 45 and that I last saw her alive on February 6 19 45

Immediate cause of death	DURATION
Cerebral Embolism	2 hours
Due to: Hypertensive Heart Disease	11 years
Due to:	
Other conditions: Schizophrenia, Reke - Phrenic Type (Include pregnancy within 3 months of death)	17 years

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hohman M.D.
M. D. or other
Address: Springfield State Hosp. Date signed: 2-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01594

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL - WESTMINSTER
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: RURAL - WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: AMELIA E. WAGNER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: JOHN T. WAGNER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 5, 1854

8. AGE:

Years	Months	Days	If less than one day
90	3	6	..... hrs. ..... min.

9. Birthplace: CARROLL COUNTY MD.
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER
12. Name: ALEXANDER G. SHIPLEY
13. Birthplace: MD.

MOTHER
14. Maiden name: MARY BROTHERS
15. Birthplace: MD.

18. Interment: ELSIE E. HOOK
Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 2/14/45 (month) (day) (year)

Cemetery or crematory: ZION CEMETERY

Location: CARROLL CO. MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 2/13/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 11 19 45, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 19 45 to Feby 11 19 45
and that I last saw her alive on Feby. 10 19 45

Immediate cause of death	DURATION
Dilatation, acute Cardiac	Annual Amos
Due to Chronic Interstitial	
nephritis	5 yrs
Due to arterio sclerosis chronic	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas R Foutz, M.D.
M. D. or other

Address: Westminster MD Date signed 2-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

01595

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Wilson Warner

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name ~~of husband or~~ wife Mary E. Warner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 22 - 1865

8. AGE: Years 80 | Months 1 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Frederick County Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Warner
13. Birthplace Maryland

MOTHER 14. Maiden name Susan Fisher
15. Birthplace Maryland

16. Informant Mrs. Mary E. Warner
Address New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28-1945 (month) (day) (year)
Cemetery or crematory Big Creek Cemetery
Location Uniontown Road

18. Funeral director H. H. Hartsler & Sons
Address Union Bridge & New Windsor Md.

19. Feb 25 1945 Ernest Dewalt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945, at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 1945 to Feb. 24 1945 and that I last saw h.. alive on Feb. 24 1945

	DURATION
Immediate cause of death Cerebral hemorrhage	
Due to Arteriosclerosis	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE James T. Shorb M. D.
Address New Windsor Md. Date signed Feb. 25/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

01596

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Linebore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Linebore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Valentine Wentz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ellen Tracey Wentz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1850

8. AGE: Years	Months	Days	If less than one day
94	1	2 2	..... hrs. ..... min.

9. Birthplace: York Co. Penna.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Abdel R. Wentz
13. Birthplace: York Co. Penna.

MOTHER
14. Maiden name: Mandilla Wolfgang
15. Birthplace: Carroll Co. Md.

16. Interment: H. T. Wentz
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12, 1945 (month) (day) (year)
Cemetery or crematory: Lazarus Union Cemetery
Location: Linebore, Md

18. Funeral director: H. C. Feikle
Address: Glen Rock, Penna.

19. Feb. 10/45 (Date rec'd by registrar) 19 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 8, 1945 19..... at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... and that I last saw him alive on ..... 19..... I [illegible] the body after death.

Immediate cause of death: Coronary Thrombosis — DURATION: ½ hour

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. M. Resh. M.D.
M. D. or other
Address: Hampstead Md. Date signed: 2/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01597

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 22 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 202 College Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME SIRANDAL WILCOX

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife Gerard Wilcox
6.(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) July 10, 1920

8. AGE:

Years	Months	Days	If less than one day
24	7	2	....hrs. ....min.

9. Birthplace Edesville, Maryland
(Town, county, and state)

10. Usual occupation Defense Worker

11. Industry or business

FATHER
12. Name Alfred Thomas
13. Birthplace Unknown

MOTHER
14. Maiden name Fannie Golden
15. Birthplace Edesville, Maryland

16. Informant Reuben Hoffman, M.D.
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/45 (month) (day) (year)
Cemetery or crematory Edesville
Location Rock Hall, Kent Co. Md.
18. Funeral director Marvin V. Williams
Address Chesterton Maryland

19. Feb. 12, 1945 (Date rec'd by registrar) Albert R. Swanbacker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1945 at 7:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1944 to Feb. 12, 1945 and that I last saw h... er alive on February 12, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1, 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the fo...
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other
Address Henryton, Maryland Date signed 2-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

01598

CERTIFICATE OF DEATH

Reg. Diat. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Rural ---Mt. Airy,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place ot death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural --- Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Raymond Williams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 4, 1889

8. AGE: Years	Months	Days	If less than one day
45	7	7	...hrs. ...min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Daniel Williams
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucille V. Ryan
15. Birthplace: Maryland

16. Informant: Mrs. Lucille V. Williams
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 2-14--45 (month) (day) (year)
Cemetery ~~or crematory~~: Mt. Zion
Location: near Mt. Airy, Carroll Co. Md.

18. Funeral director: C .M. Waltz
Address: Winfield, Md.

19. Feb. 7th 1945 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11 1945, at 12:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Broken Neck - Fractured Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 2-11-45
Where did injury occur? Mt Airy (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?) Route # ~~[illegible]~~ 27
Means of injury: Struck by automobile Injured at work? No.

23. SIGNATURE: James T. Marsh. Deputy Medical Examiner
M. D. or other
Address: New Windsor Md Date signed: Feb 11 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01599

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 6 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1402 Madison Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: IRENE JEANETTE WILLOUGHBY

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Richard Willoughby
6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): March 16, 1924

8. AGE: Years	Months	Days	If less than one day
20	10	22	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home
FATHER 12. Name: Louis Johnson
FATHER 13. Birthplace: Lancaster County, Virginia
MOTHER 14. Maiden name: Nora Johnson
MOTHER 15. Birthplace: Northumberland Co., Va.
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 14-45 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: Ardmdyl. Co.
18. Funeral director: Geo. L. Kelson
Address: 1303 Prestman
19. 2/7 (Date rec'd by registrar) 19 45 Albert R. Sandhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7, 19 45 at 2.45P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept., 1, 19 44 to Geb., 7, 19 45
and that I last saw her alive on February 7, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: July 15, 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01600

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 5 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: DOROTHY LUCILLE WILLS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 4, 1922

8. AGE: Years	Months	Days	If less than one day
22	6	28	hrs. min.

9. Birthplace: Bel Alton, Md.
(Town, county, and state)

10. Usual occupation: Worker in tobacco factory

11. Industry or business

FATHER
12. Name: Johnny Wills
13. Birthplace: Unknown

MOTHER
14. Maiden name: Elizabeth Garner
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5-1945 (month) (day) (year)
Cemetery or crematory St Ignatius
Location Bel Alton, Md
18. Funeral director Hurtt & Ryon
Address Waldorf Md

19. Feb. 1, 1945 (Date rec'd by registrar) Albert R Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: February 1, 1945, at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27, 1944 to Feb. 1, 1945 and that I last saw him alive on February 1, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
Address: Henryton, Md. M. D. or other
Date signed 2-1-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

016[illegible]

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos 4 da
Hospital, institution, or street address (if not in hospital): Springfield State Hospital
How long in hospital or institution? 5 mos 4 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2317 W North Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary D Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	divorced

6.(b) Name of husband or wife: Guy Wilson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb 13th 1880

8. AGE:

Years	Months	Days	If less than one day
65		10	hrs. min.

8. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Sales Clerk
11. Industry or business:

FATHER
12. Name: Abraham Hayden
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucy Downs
15. Birthplace: Maryland

16. Informant: Mrs David Shindler
Address: 2317 W North Ave Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 1, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. Mar 1 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23d 1945 at 7-15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19th 1944 to Feb 23 1945
and that I last saw h[illegible] alive on Feb 23 1945

	DURATION
Immediate cause of death:	
Chronic Hypocardites	10 yrs
Due to:	
Ch. Interstitial Nephritis	5 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. H. Gaston MD (M. D. or other)
Address: Sykesville Date signed 2-24-45

VS A15

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MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47

01602

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 1 month
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 years, 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3125 Mareco Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Richard Wissner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Gertrude Caroline Snyder 6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): January 7, 1886

8. AGE: Years	Months	Days	If less than one day
59	1	1	...hrs. ...min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: Cooperman

11. Industry or business: Railroad warehouse

FATHER
12. Name: John Wissner
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Catherine Kolb
15. Birthplace: Baltimore City, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Feb. 10, 1945 (month) (day) (year)
Cemetery or crematory: Baltimore County
Location: Balto. Md.

18. Funeral director: Joseph Ferrase
Address: Greenmount ave., Balto. Md.

19. Feb 8 1945 C. Harry Weis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 1945, at 12:35p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to Feb. 8 1945
and that I last saw him alive on February 8 1945

Immediate cause of death	DURATION
Bronchogenic carcinoma	1 year
Due to:	
Due to: Arteriosclerosis and hyper-	
tension, prior to	1942
Other conditions: involutional psychosis,	
melancholia	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 2-8-45

MARGIN RESERVED FOR BINDING

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VS A15